ncp
NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER

WINTER 1996, Volume 6, ISSUE 1, ISSN-1052-7168

Clinical Quarterly

Menlo Park/Palo Alto * Boston * Honolulu * West Haven * White River Junction

THE PSYCHOLOGICAL DEMANDS OF PEACEKEEPING FOR MILITARY PERSONNEL

Brett T. Litz, Ph.D.

The end of the Cold War has marked a period of inter-ethnic conflict, civil war and humanitarian disasters throughout the world. Several recent wars, such as in the former Yugoslavia, have created such profound tragedy (e.g., massive numbers of refugees, threats of genocide) that the United Nations (UN) and other multinational organizations (e.g., NATO) have interceded, providing humanitarian relief, protecting civilians who are at risk, peacekeeping, and, in many instances, providing armed enforcement of peace (1,2). In fact, the UN has established more peacekeeping operations, and has deployed more men and women peacekeepers in the 1990's, than in all the other years in the history of the UN combined (3). The imposition of peace by the UN is particularly controversial, and sociologists and military strategists have written much about the implications of such a policy (4-5). However, until recently, mental health practitioners and researchers have

Continued on page 3

Photo by Carlos Fernandez

Inside this EDITION

FROM THE EDITOR...

WARNING!!! Studies reveal that your job may cause you inordinate stress the rest of your life.

Trauma research continues to uncover and re-confirm a harsh reality: many jobs that societies depend on place individuals at risk for life-long biological, psychological, social and spiritual impairment. Numerous studies, including reports presented in this and other issues of the *Clinical Quarterly,* indicate that emergency workers of all types, be they peacekeepers, soldiers, rescue workers, medical technicians, firefighters, police, or counselors, are at risk for developing what Charles Figley has termed "compassion fatigue," or in more severe cases, PTSD. It seems to us that what has been learned about the impact of PTSD on veterans and about clinical interventions to prevent or ameliorate the psychological impact of traumatic exposure, is applicable to nonveteran men and women who may also be at risk for PTSD because of their occupations. The National Center has been working to disseminate such information to relevant governmental and non-governmental organizations and is continuing to develop collaborative research and educational activities to assist in this regard. We hope that such efforts will reduce the number of veterans and nonveterans who develop or suffer from PTSD.

This Winter edition of the *Clinical Quarterly* highlights issues related to peacekeeping stress with articles by **Brett Litz, Tom Lundin** and **Ulf Otto**, and **Lars Weisaeth, Lars Mehlum**, and **Mauritz Mortensen**. In addition, a treatment program for Southeast Asian refugees is presented by **James Boehnlein** and **David Kinzie**, This issue also marks the inaugural appearance of *Practitioner Network*. Edited by **Julian Ford**, this regular column will provide descriptions of innovative approaches to clinical and preventive services as well as reports on program development and evaluation being undertaken by specialized PTSD programs and practitioners.

The Spring issue of the *Quarterly* will feature articles by **John Briere, Victoria Follette** and **Steven Hays, Jill Serafin**, and **Susan Ansorge** highlighting clinical considerations related to treating the residual effects of childhood abuse in adults as well as the theoretical and clinical issues related to self-acceptance and emotional processing.

From all of us at the National Center for PTSD, we wish you a new year enriched by peace, goodwill, and understanding.

Bruce H. Young, Editor

ncp
NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER

Clinical Quarterly Staff

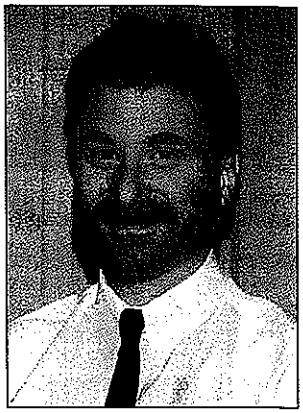
Editor	BRUCE H. YOUNG, M.S.W., L.C.S.W.
Managing Editor	JOE RUZEK, PH.D.
Executive Editor	FRED D. GUSMAN, M.S.W.
Associate Editor	DUDLEY D. BLAKE, PH.D.
Assistant Editor	JOHN ABOYTES, B.A.
Copy Editor	ANNABEL PRINS, PH.D.
Graphic Designer	VALLEY COLOR GRAPHICS, MODESTO, CA

Please feel free to contact us at the education division: FTS 463-2673/2494; commercial number 415-493-5000 ext. 22673/22494; or E mail: bhh @ icon. palo-alto. med. va. gov
Please address all correspondence to: Editor, *National Center for PTSD Clinical Quarterly,* VA Palo Alto Health Care System, 3801 Miranda Avenue 323E112, Palo Alto, California 94304.

paid little attention to the psychological consequences of such duty for the men and women who serve.

Historically, there has not been much apparent need for considering the psychological demands of peacekeeping. The role of the military in peacekeeping operations has traditionally been that of maintaining a strictly neutral presence by overseeing peace accords between formerly warring parties (2). Small forces from non-super-power nations conducted peacekeeping in this type of context and were very proud of their role as peacekeepers. Peacekeeping deployment was typically exciting and interesting, or at times, mundane and boring (5).

Given recent events (e.g., Bosnia, Somalia), it is timely to reflect on the manner in which peacekeeping has changes and to examine the psychological challenges these changed represent. To put it simply, peacekeeping in the post-Cold War is more dangerous and conflict-laden. The present paper is primarily designed to explicate the types of stressful experiences that peacekeepers are exposed to, particularly in the post-Cold War world, that may put them at risk for the development of psychological problems including Posttraumatic Stress Disorder (PTSD). To this end, brief summaries of the stressors associated with peacekeeping from the perspective of four different peacekeeping missions that roughly represent a continuum of peacekeeping stressors will be presented (see Figure 1): The Sinai (starting in 1979), Lebanon (starting in 1982), Somalia (starting in 1991), and Bosnia (starting in 1991). These operations illustrate the broad variety of peacekeeping missions, from the benign, strictly observer operation in the Sinai, to the highly dangerous peace-enforcement missions in Somalia and Bosnia. It seems certain that clinicians who treat PTSD in veteran populations will in the future be targeting peacekeeping-related stress and trauma. Given that there are few empirical studies that have examined the psychological outcomes associated with exposure to peacekeeping stressors, the present paper also attempts to extract common themes about peacekeeping under dangerous conditions that may put peacekeepers at risk for lasting psychological dysfunction. It is hoped that this effort can contribute to an emerging dialogue about the



Brett Litz, Ph.D.

Figure 1. Stressors associated with peacekeeping missions.

	Low stressors	Moderate to High stressors	High ——— to ———	Extreme stressors
Examples:	**Sinai**	**Lebanon**	**Somalia**	**Bosnia**
Characteristics:	Firmly established peace.	Tenuous peace; Flare-ups of conflicts.	Inter-clan violence; Ongoing skirmishes.	Ongoing war; Genocide; Atrocities.
Context:	Uncontested presence; Command structure and rules are clear and unequivocal.	Lightly armed troops out-armed; Peacekeepers are from small nations; Poor supplies; Use of force is severely restricted.	Somalia was unruly and unsafe; Ongoing life threat to UN-personnel from civilians.	UN personnel have little power; outarmed; Difficult to to maintain neutrality.
Duties:	Observe, monitor, report; Constabulary.	Observe, monitor, report; Patrol; Provide buffer-zone; Constabulary.	Patrol, disarm; Provide humanitarian aide. Build infrastructure.	Provide buffer-zones and "safe" havens.
Potentially traumatizing events:	Accidents; Abductions; Assassination attempts.	Sudden, unpredictable attacks, hostage-taking, witnessing violence.	Sniper attacks, mines, witnessing starvation, violence.	Sniper, mortar attacks; Witnessing atrocity; Being held hostage.
Psychological challenges:	Boredom; Role-conflict; Confinement; Risk of terrorism still present.	Helplessness, powerlessness, isolation, cynicism, demoralization, guilt over acts of omission, over-controlled aggression.	Frustration with rules of engagement; Demoralization; Hostility and anger; Witnessing death and violence.	Extreme powerlessness; Guilt; Terror; Moral conflict; Role-conflict.

psychological demands of peacekeeping by generating information that may be useful for training future peacekeepers as well as for treatment of peacekeeping-related stress.

The Muitinational Force and Observers in the Sinal (MFO)

Since the establishment of the state of Israel in 1948, the UN and other multinational organizations have engaged in an ongoing struggle to create and maintain peace between Israel and its neighbors. An example of a very successful attempt to maintain peace in the region is the MFO in the Sinai. The Camp David Accord in 1979 between Israel and Egypt led to the establishment of the MFO in order to oversee the withdrawal of Israeli forces from the Sinai. The MFO force consisted of over 3000 professional soldiers and civilian observers from 11 nations (6). The US supplied an elite infantry battalion (combat troops) to the Sinai. Due to the stability of the peace between Israel and Egypt and the receptiveness of both parties to the presence of the MFO, peacekeepers in the Sinai have been exposed to very little in the way of potentially traumatizing events directly related to their service as peacekeepers. The mission in the Sinai therefore represents the end of a continuum of peacekeeping stressors (see Figure 1).

In a successful peacekeeping mission such as in the Sinai, the duty of peacekeepers is strictly to observe, monitor, and report. The actions of peacekeepers in this context are absolutely necessary and functional but nevertheless, perfunctory. This is not to say that such duty is completely risk free; peace observers are always at risk for exposure to terrorism and flare-ups of conflicts. Successful peacekeepers are nonetheless like a constabulary in this regard; they operate like cops on a beat who by their presence deter violations of peace treaties (5). Peacekeepers from smaller nations who have a proud history of providing observer forces are very comfortable with the constabulary role. However, for combat-trained soldiers from larger nations, conflict can arise because they experience peacekeeping duty as "underwhelming" and incongruent with their training. Although highly trained combat soldiers who participate in the policing and monitoring of an established peace can be frustrated by role conflict, these same soldiers have been shown to be the best peacekeepers (5). Professional soldiers are more likely to appreciate the necessity of order and discipline, regardless of the types of duty they are performing. Well-trained professional soldiers also are more likely to benefit from group cohesion and strong morale.

The UN Interim Force in Lebanon (UNIFIL)

Israel invaded southern Lebanon in 1978 and occupied most of the area. Subsequently, Israel accepted the terms of a UN agreement (initially) and withdrew from Lebanon under the supervision of the UNIFIL which was created to monitor the activity in southern Lebanon and to restore peace and security during the civil war which ensued after Israel's formal withdrawal. The peacekeeping mission in Lebanon was not successful in terms of its global goals. Civil war and political instability have overshadowed Lebanon. In addition, the peacekeeping mission in Lebanon has had structural and strategic problems that are examples of the types of problems that plague peacekeeping missions under tenuous and dangerous circumstances. As reported by Gravino et al. (6), these problems are: "..inconsistencies between national contingents, conflicting loyalties between UN and national authorities and policies, poorly trained and equipped contingents, particularly from some of the developing countries, isolation of staff headquarters from field units, and bias- in this instance among some African contingents toward the host populations" (pp. 32-33). It is likely that the stress from dangerous peacekeeping missions is compounded by disorganized command and control processes. At the very least, ambiguity, confusion and disarray are factors that adversely affect morale and group cohesion which have been shown to mediate acute stress reactions during deployments to military operations (7-8). Indeed, Weisaeth (9) found that in a contingent of Norwegian peacekeepers deployed to Lebanon, "psychologically protective factors such as good leadership, strong group-feeling and high motivation proved to be of immense importance and increased the soldier's tolerance to stress well beyond average" (p. 115).

One incident that exemplifies the danger involved in the mission in Lebanon is the terrorist bombing that killed 240 Marines at the Marine headquarters in Beirut, in October, 1983. This incident underscores the vulnerability of peacekeeping forces, regardless of their size or offensive capability. Large, powerful and apparently fortified forces, such as the US force in Beirut are particularly attractive targets for terrorism (6). Moreover, smaller, out-armed peacekeepers in Lebanon are particularly good targets for taunting, humiliation, and hostage taking.

Over the years, UN peacekeepers in Lebanon have been subjected to a number of different types of potentially traumatizing events, including: terrorist attack, sniper fire, extreme humiliation and taunting, and hostage-taking. The role of UN peacekeepers in Lebanon can best be described as a buffer between two or more sides that would rather be at war. Often, the conflicting parties would attempt to provoke UN personnel from their neutral stance so as to reduce their credibility and compromise their mission (10).

Weisaeth and his colleagues have comprehensively studied Norwegian peacekeepers who were deployed to Lebanon between 1978 and 1992 (11). These researchers have shown that while the frequency of war-zone-like stressor events (e.g., being fired at) was quite low in UNIFIL soldiers, many peacekeepers were frightened of being injured and had witnessed violence to civilians. In the Norwegian UNIFIL study, 9% of subjects reported firing a weapon during their service, 9% reported being held by either the Lebanese or the Israelis against their will for a period of time, 23% reported being humiliated and taunted, 33% reported witnessing violence against civilians, 20% reported protecting civilians from violent attacks, and 28% reported being afraid of being wounded at least part of the time. Weisaeth and his colleagues (The UNIFIL Study, 1993) estimated that 17% of Norwegian UNIFIL soldiers reported clinically significant symptoms of PTSD, and 5% met conservative criteria for a formal diagnosis of PTSD.

Interestingly, 22% of subjects in the Norwegian UNIFIL study reported that they sometimes felt in doubt about what to do in threatening situations. This echoes one of the inherent psychological challenges of peacekeepers exposed to dangerous situations: ambiguity about applying force and the need to show restraint in response to life threat. Peacekeepers who are unclear about how to respond to threats and/or experience repeated threats of injury, with little, or no opportunity for recourse, are likely to experience great anxiety. This kind of military duty creates a sense of vulnerability that is unique to peacekeeping (12). Several clinical researchers have hypothesized that repeated acts of exhibiting restraint in the face of danger puts peacekeepers at risk for the development of problems related to rage and aggression (9,13). Peacekeepers who suppress their frustration, fear, resentment and anger are at risk for acting-out their feelings both during

a mission (e.g., unnecessary acts of violence, callousness, dehumanization of one or more parties), and / or upon their return home (e.g., reduced empathy toward significant others, quick temper, etc.).

Operation Restore Hope (ORH) and Operation Continue Hope (OCH) in Somalia

The UN, with extensive support from the US, decided to guarantee the provision of humanitarian aide as well as to enforce the peace in Somalia. Although ORH was a great success in regard to the provision of medical and food supplies (14), the mission is likely to be considered a failure experience for many who served. As of April 1994, all peacekeepers have left Somalia. However, Somalia is currently at risk for the devastating effects of famine, and political instability and violence still plague the country. The peacekeeping mission in Somalia has taught many painful lessons and underscores many of the problems with peacekeeping missions under dangerous, unstable situations, particularly for US military personnel.

The following is based on a large scale study that my colleagues (Friedman, Orsillo, Ehlich, Roemer, Fitzgerald, and Batres) and I have undertaken to explore the psychological sequelae of peacekeeping for US military personnel in Somalia. We used many sources of information about the experience of US military personnel in Somalia in our study of peacekeepers. To get a sense of the phenomenology of deployment to the peacekeeping mission in Somalia, our research team interviewed several officers who were deployed to Somalia as part of stress control teams. One member of our research team also performed critical incident stress debriefing of groups of soldiers upon their return to the US (15). We have also conducted an empirical evaluation of the nature of the mission in Somalia as well as the psychological outcome associated with peacekeeping service via a survey study of a large cohort of Somalia veterans (N=3461) approximately five months after their return to the US.

Peacekeepers in Somalia performed a variety of tasks, mostly designed to secure the provision of humanitarian aide. Many soldiers were assigned police-type duty, while others were tasked with even more dangerous war-zone-like activity (e.g., patrols, disarming civilians). Peacekeepers were exposed to a fairly well armed civilian population who were actively engaged in inter-clan war. Strict rules of engagement sharply restricted peacekeepers' options for protection or retaliation. There were two primary sources of role conflict for US soldiers who were deployed to Somalia, particularly those soldiers who were trained for combat and combat-support duty: (a) being restrained in offensive response to conditions of life-threat, and (b) being exposed (like a cop on the beat) to an armed and hostile civilian population with inadequate defenses. The types of defensive military structures that are commonplace in war were not as available in Somalia due to one of the absolute requirements of peacekeeping and peace-enforcement in such missions, namely, close proximity to the recipients of humanitarian assistance and protection. The emphasis on proximity rather than protection will create considerable hypervigilance and arousal in peacekeepers and contribute to a general sense of fear, perhaps in particular for soldiers trained for combat roles.

Veterans of the Somalia mission were also subject to threats and resentful, hostile rejection by recipients of humanitarian aide. This type of treatment is likely to have produced demoralization and counter-resentment in peacekeepers in Somalia. Somalia veterans may have ended up being particularly cynical and demoralized by the fact that the mission ended unsuccessfully and the country is still in a state of civil war. Veterans of the mission might end up asking themselves, "Why did we go to Somalia, was it worth it...?" In this regard, we found in our study of Somalia veterans that perceptions of the rewards of the humanitarian mission did not contribute to the prediction of PTSD or general psychological distress (12).

The events that unfolded in last phase of the US military's involvement in Somalia (OCH) deserve particular attention and careful study because they reveal a great deal about the unique difficulties of peace-enforcement interventions. During OCH, the UN had some operational command over the activities of US soldiers, rather than exclusively being under US political and military command (which was the case during ORH). Also during OCH, the UN broke the traditional neutrality associated with peacekeeping and mandated that the Somalia warlord, Colonel Aidid be ousted. This was the first peace-*enforcement* operation in the history of the United Nations (16). Consequently, OCH was distinguished by a sharp increase in offensive engagements with Somali clansmen and a decrease in US domestic support for the mission (culminating in the October, 1993 raid on Aidid's forces which led to the capture of helicopter pilot Michael Durant; (17)). Ultimately, OCH was unsuccessful and propelled the withdrawal of the US military from Somalia.

The results of our study suggest that those Somalia veterans who reported few symptoms of psychological distress or PTSD were more likely to feel positive about military cohesion and morale during their deployment.

Although there were many potentially traumatizing dangers and psychological conflicts associated with deployment to Somalia for US military personnel, the great majority of soldiers appeared to have adapted well to the experience (12). The results of our study suggest that those Somalia veterans who reported few symptoms of psychological distress or PTSD were more likely to feel positive about military cohesion and morale during their deployment. Thus, as Weisaeth (9) and others have suggested, it appears that, from a mental health perspective, successful peacekeepers are professional soldiers who are more likely to feel pride and cohesion about their military service and greater confidence in the order and structure of the military.

However, for a small but significant percentage of Somalia veterans, psychological costs accompanied their involvement in the mission in Somalia, particularly for those soldiers who were deployed during OCH (12). Approximately 25% of Somalia veterans studied reported clinically

significant psychological distress, particularly hostility and anger problems. Hostility and anger problems may be particularly prevalent in this population because of the frustration of exhibiting restraint in the face of life threat. Somalia veterans who were deployed to OCH had more hostility and anger problems than their counterparts who were deployed to ORH. In addition, OCH deployment was associated with reports of more severe PTSD symptoms. These latter two findings suggest that peacekeepers have a harder time coping with peacekeeping missions that escalate into a war-like posture.

In our study of Somalia veterans, a member of our research team interviewed a subset of Somalia veterans using the Clinician Administered PTSD scale (CAPS; 18). The CAPS data were used to generate optimal cutoffs on the PTSD measures used in the larger survey study to estimate PTSD prevalence associated with Somalia service. Eight percent of the Somalia veterans studied met diagnostic criteria for PTSD. Table 1 shows several illustrative examples of Criterion-A events that the Somalia veterans who were found to have PTSD reported on the CAPS. These data are presented to allow the reader to get a sense of peacekeepers' exposure to traumatizing events in Somalia. The themes that can be extracted from the PTSD subjects' report of traumatizing events are: (a) being a victim of war-zone violence, (b) witnessing violence or the aftermath of violence, and (c) witnessing the effects of starvation.

We also examined the factors that were predictive of PTSD in our Somalia study. The single most robust statistical predictor of the severity of was the interaction between extent of exposure to stressful war-zone events (e.g., going on dangerous patrols) and frustrations with aspects of the peace enforcement mission (e.g., restrictive rules of engagement). The relationship between war-zone exposure and PTSD was strongest for Somalia veterans. This interaction effect was such that among those Somalia veterans with high levels of frustration with the negative aspects of peacekeeping duty there is a stronger relationship between war-zone exposure and PTSD, than among those participants who were less frustrated by the negative aspects of peacekeeping.

Thus, peacekeeping operations under perilous conditions, where life threat occurs in the context of restrictive rules of engagement and poor defenses, represent a unique class of potentially traumatizing events not captured by traditional descriptors of war-zone exposure alone. To the extent that the experience in Somalia can be generalized to other peacekeeping missions under similar unstable conditions, the interaction of war-zone stress and peace enforcement may represent the prototype of a new paradigm in military operations. It could be that this interaction of war-zone exposure and peace-enforcement is most implicated in PTSD because it relates to the extent to which soldiers are exposed to danger that is uncontrollable and unpredictable, features that have been proposed to create risk for PTSD (19, 20).

Table 1. Examples of the Criterion-A events reported by PTSD Somalia veterans administered the CAPS.

- Grenades hit a vehicle behind a veteran and a land mine blew-up a vehicle in front. In addition, the veteran was shot at.
- Veteran felt intense fear while driving in convoys under dangerous conditions.
- Veteran witnessed the bloody aftermath of the attack on the army rangers in Mogadishu in Operation Continue Hope.
- Veteran was shot. He was medic who treated caualties in a helicopter crash.
- Veteran witnessed severe starvation of Somalis in countryside.
- Veteran came under fire in a convoy; bullets hit his vehicle.
- Veteran had a weapon pulled on him that misfired.
- Veteran saw many dying children.

UN Protective Force in The Former Yugoslavia

When Bosnia declared itself a separate state in 1992 the UN acted to guarantee its sovereignty by protecting it from subsequent Serb attacks. The Serbs had acted on the threat of losing territory they had in Bosnia and on old race-based hatreds. The Serbs have apparently committed genocidal atrocities that have been euphemistically termed "ethnic cleansing," although it is likely that all sides in the civil war have committed atrocities. For the various ethnic and political groups living in the former Yugoslavia, the zeal for retribution and acting-out of formerly suppressed hatred has far outweighed concerns about humanity and any future-oriented goal of nation building.

The final chapter has yet to be written about the UN peacekeeping and peace-enforcement efforts in Bosnia and events are unfolding while this paper is being written. The area known as Bosnia-Herzogovina continues to be decimated by war. Currently, there are approximately 42,000 UN peacekeepers in the former Yugoslavia (in Croatia, Bosnia, and Macedonia). The UN created protective regions and cities in Bosnia and has supplied UN forces, mostly from France and the United Kingdom to ensure these areas are safe from Serb aggression. After repeated taunting, bullying and violent attacks by Serb forces, several of these areas had fallen into Serb hands. In fact, one of the uniquely gruesome features of the mission in the former Yugoslavia for UN peacekeepers is not only their failure to secure several "safe" havens, but in some instances peacekeepers had to stand by helplessly while atrocities were taking place. For example, after Srebrenica fell into Bosnian Serb hands in July 1995, Dutch peacekeepers stood by while Serb soldiers separated men of military age from other civilians (21). The Serb soldiers took some of these men away on trucks, while the Serbs took others into a warehouse where dead bodies were later found. These incidents underscore the extreme vulnerability and powerlessness of UN peacekeeping forces who are out-armed by combatants.

Other UN safe havens have held firm, such as Sarajevo, but have been subject to repeated brutal shelling and sniper attacks. Peacekeepers act as a buffer against hostilities and a deterrent from aggressive acts against civilians in protected areas. However, attacks persist and UN forces are typically quite powerless to prevent attacks. Peacekeepers have also had to address the humanitarian needs of the refugee victims of the war who are often wounded and always traumatized. Some peacekeepers have been taken hostage and used as threats against counterattacks to Serb aggression. Needless to say, these experiences put the soldiers of the peacekeeping mission in Bosnia at risk for the development of PTSD. Greg Passey, a military psychiatrist in Canada, examined the adaptation of more than 1,000 Canadian military personnel who served in the peacekeeping mission in Bosnia (22, 23). His results suggested that more than 20% of the soldiers endorsed symptoms of PTSD and depression.

The use of NATO air-strikes against Serbian positions has led to the Americanization of the war. Furthermore, currently, the US appears to

be committed to following-up on political initiatives to create and maintain peace, by deploying tens of thousands of peacekeepers to Bosnia. Thus it appears likely that US military will once again be exposed to a peacekeeping mission under dangerous conditions that may escalate into war-zone-like activity.

Tentative Conclusions and Recommendations

Dag Hammarskjold, the late secretary-general of the United Nations (UN) is often quoted as having said that peacekeeping is not a job for soldiers, but that only soldiers can do peacekeeping (24). This observation about the inherent conflict of peacekeeping was prescient and is even more true in the post-Cold War world then in the world of the 1950's. On the one hand, peacekeeping, in principle, requires observation and monitoring of politically guaranteed peace accords. Peacekeepers in this rather ideal context are like an impartial and neutral police force, a role that can be at odds with the combat soldier's ethic (5). On the other hand, as repeatedly demonstrated in practice, peace is a tenuous process and peacekeepers are exposed to ongoing, unpredictable and uncontrollable life-threat akin to a special type of war-zone (12). Peacekeeping under these circumstances requires both the offensive and defensive capability of trained combat soldiers. However, peacekeeping under tenuous and dangerous conditions also requires impartiality, neutrality, and a great deal of patience and restraint, qualities that are not typically endorsed in the doctrine of military affairs. Clearly then, a key psychological demand of peacekeeping is role conflict.

Peacekeeping requires the skill and discipline of professional soldiers. However, the military may need to modify their training doctrine for those soldiers who are deployed to peacekeeping interventions. In training future peacekeepers, the US military, in particular, will need to modify the ethic of pursuing a particular enemy and obtaining a military victory as the sole role of soldiers. Training should address the conflict that soldiers will have about neutrality and restraint in the face of life-threat.

It is vitally important to pay special attention to the mental health needs of soldiers who return from peacekeeping missions, particularly ones that entail unforeseen escalation in hostilities. Soldiers should be systematically evaluated for signs of psychological distress and other mental problems and given opportunities for rest and unrestrained expression of their feelings about the mission (25). The more a peacekeeping mission becomes a peace-making or peace-enforcement mission, the greater the likelihood that such deployment exposes soldiers to potentially traumatizing events. Peace-enforcement missions will also require treatment of acute traumatization in the field of operation (25) and standard debriefing for soldiers after their return home.

It could be that this interaction of war-zone exposure and peace-enforcement is most implicated in PTSD because it relates to the extent to which soldiers are exposed to danger that is uncontrollable and unpredictable, features that have been proposed to create risk for PTSD.

At the time of writing this last section, a peace accord has been signed by all parties in the former Yugoslavia, and the US has embarked on a massive peacekeeping mission in Bosnia. It is interesting to note how the US military has evolved in their doctrine about peacekeeping in light of the demands of the Bosnia mission and in the context of the previous mission in Somalia. The US military is using more heavily fortified defensive structures as well as armored mobile units to patrol zones of separation in Bosnia. The military have emphasized that in this peacekeeping mission, US soldiers will be allowed to defend themselves in highly aggressive ways if they are threatened. Finally, the US has set an *a priori* date for the withdrawal of US forces to reduce the likelihood of demoralizing "mission creep." It is clear that these various changes in policy and method reflect painful lessons learned about the nature of peackeeping in dangerous areas and are likely to reduce role conflict and ambiguity, and may reduce perceived threat related to peackeeping duty in Bosnia. What is not clear, however, is whether the new methods will accomplish the mission of ensuring the peace (e.g., will there be sufficient proximity of contact? Will soldiers be perceived as uncaring or disengaged?) or whether the greater fortification and more liberal rules of engagement actually function to reduce role conflict and risk for PTSD should flare-ups of the conflict occur.

The deployment of 20,000 US soldiers to Bosnia in the winter of 1995 for a peacekeeping operation continues a trend that signifies how central peacekeeping has become in US military affairs. It appears that a paradigm shift has occurred which underscores the need to begin to examine the long-term mental impact of peacekeeping in veterans of such missions.

References

1. Henshaw, J. H. (1993). Forces for peacekeeping, peace enforcement, and humanitarian missions. In B.M. Belchman,W. J. Durch, D. R. Graham, J. H. Henshaw, P. L. Reed, V. A. Utgoff, & S. A. Wolfe (Eds.), *The American military in the 21st century* (pp. 397-430). New York: St. Martin's Press.
2. Moskos, C. C., & Burke, J. (1994). The postmodern military. In J. Burke (Ed.), *The military in new times* (pp. 141-162). Boulder, CO: Westview Press.
3. Boutrous-Ghali, B.(1992). *An agenda for peace*. New York: United Nations.
4. Marks, E., & Lewis, W. (1994). *Triage for failing States*. Washington, D.C.: National Defense University Press.
5. Segal, D. R., & Segal, M. W. (1993). Research on soldiers of the Sinai multinational force and observers. In D. R. Segal & M. W. Segal (Eds.), *Peacekeepers and their wives* (pp. 56-69). Westport, CT: Greenwood Press.
6. Gravino, K.S., Segal., D.R., Segal, M. W., & Waldman, R.J. (1993). The middle east: Crucible of peacekeeping. In D. R. Segal and M. W. Segal (Eds.), *Peacekeepers and their wives* (pp. 27-41). Westport, CT: Greenwood Press.
7. Belenky, G.L., Noy, S., & Solomon, Z. (1987). Battle stress, morale, "cohesion," combat effectiveness, heroism, and psychiatric casualties: The Israeli experience. In G. Lucas (Ed.), *Contemporary studies in combat psychiatry* (pp. 11-20). Westport, CT: Greenwood Press.

8. Milgram, N. (1993). War-related trauma and victimization. In J.P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 811-820). New York: Plenum.
9. Weisaeth, L. (1982). Psychiatric problems of UNIFIL and the UN-soldiers stress syndrome. *International review of the Army, Navy, and the Air Force Medical Services, 55*, 109-116.
10. Mehlum, L. (1994, June). Positive and negative consequences of serving in a UN peace-keeping mission. A follow-up study. Paper presented at the annual meeting of the International Congress of Military Medicine, Augsburg, Germany.
11. Weisaeth, L., Aarhaug, P., Mehlum, L., & Larsen, S.(1993). *The UNIFIL study (1991-1992). Report I: Results and recommendations.* Headquarters Defence Command Norway - The Joint Medical Service.
12. Litz, B.T., Orsillo, S., Friedman, M., Ehlich, P., & Batres, A. (Manuscript submitted for publication). *An Investigation of the Psychological Sequelae Associated with Peacekeeping Duty in Somalia for United States Military Personnel.*
13. Lundin, T., & Otto, U. (1989). Stress reactions among Swedish health care personnel in UNIFIL, South Lebanon. *Stress Medicine, 5*, 237-246.
14. Cowan, M. L. (1993). Reminiscences of Operation Restore Hope. *Navy Medicine*, 1-8.
15. Ehlich, P., Fitzgerald, S., Logan, G., Batres, A., Williams, G., Gelsomino, J., & Hayes, L. (1995, October). *The effects of role ambiguity on US forces in Somalia.* Paper presented at the meeting of the International Society for Traumatic Stress Studies, Boston, MA.
16. Allard, K. (1995). *Somalia operations: Lessons learned.* Washington, D.C.: National Defense University Press.
17. DeLong, K., & Tuckey, S. (1994). *Mogadishu!: Heroism and tragedy.* Westport, CT: Greenwood Press.
18. Blake, D.D., Weathers, F.W., Nagy, L.M., Kaloupek, D.G., Klauminzer, G., Charney, D., & Keane, T.M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-1. *the Behavior Therapist, 18*, 187-188.
19. Foa, E., Zinbarg, R., & Rothbaum, B. (1992). Uncontrollability and unpredictability in post-traumatic stress disorder: An animal model. *Psychological Bulletin, 112*, 218-238.
20. Weisaetb, A.S. (1990). Stress of peace-keeping. In J.E. Lundeberg, U. Otto, and B. Rybeck (Eds.), *Proceedings: Wartime medical services, Swedish research establishment* (pp. 375-395). Stockholm: FOA.
21. Kinzer, S. (1995). Dutch conscience stung by troops' Bosnia failure. *The New York Times*, CXLV, 1, 12.
22. Birenbaum, R. (1994). Peacekeeping stress prompts new approaches to mental-health issues in Canadian military. *Canadian Medical Association Journal, 151*, 1484-1489.
23. Passey, G., & Crocket, D. (1995, November). *Psychological consequences of Canadian UN peacekeeping in Croatia and Bosnia.* Paper presented at the meeting of the International Society for Traumatic Stress Studies, Boston, MA.
24. Moskos, C.C. (1975). UN peacekeepers: The constabulary ethic and military professionalism. *Armed Forces and Society, 1*, 388-401.
25. Armfield, F. (1994). Preventing post-traumatic stress disorder resulting from military operations. *Military Medicine, 159*, 739-746.

Brett Litz is the Associate Director of the Behavioral Science Division of the National Center for PTSD and Assistant Professor in the Department of Psychiatry at Tufts University School of Medicine. Besides actively researching the psychological sequelae of peacekeeping for US military personnel, Dr. Litz has just completed a VA-funded Merit Review study of the psychophysiological parameters of emotional numbing in combat-related PTSD.

SWEDISH SOLDIERS IN PEACEKEEPING OPERATIONS: STRESS REACTIONS FOLLOWING MISSIONS IN CONGO, LEBANON, CYPRUS, AND BOSNIA

Tom Lundin M.D., Ph.D., & Ulf Otto, M.D., Ph.D.

Just a few weeks after arrival in Bosnia in October 1993, a group of young and relatively inexperienced soldiers from the first Swedish battalion in former Yugoslavia, found the bodies of 19 murdered women and children in the village Stupni Do. This tragic discovery illustrates the situation for many UN soldier who were exposed to an unexpected and overwhelming traumatic situation. To witness the effects of a massacre on innocent civilians - and not being capable to prevent or retaliate, might result in intense traumatic stress reactions.

UN soldiers from several countries have been trying to prevent extensive suffering among civilians in towns that we now associate with genocide, atrocities, concentration camps, and ethnic cleansing: Bihac, Banja Luka, Vitez, Sarajevo, Srebrenica, Gorazde. These names also should remind us that peacekeeping soldiers will be exposed to both cognitive and emotional stressors specific to peacekeeping missions (Table 1).

Table 1. Cognitive and emotional stressors faced by peacekeeping soldiers.

Cognitive
- Information: too much, too little
- Sensory overload vs deprivation
- Ambiguity, uncertainty, isolation
- Time pressure vs waiting
- Unpredictability
- Rules of engagement, difficult discriminations
- Organizational dynamics
- Hard choices vs no choices

Emotional
- Fear and anxiety-producing threats (of death, injury, failure and loss)
- Grief-producing losses (bereavement)
- Resentment, anger, and rage-producing frustration, threat and loss
- Boredom-producing inactivity
- Conflicting motives (worries about home, divided loyalties)
- Moral conflicts

More than 60,000 Swedish military personnel have been in UN-service since the 1951-52 operations in Greece. Kettner (1) conducted the first study on Swedish UN soldiers, all of whom had been exposed to combat during the hostilities in the Congo in 1961. This study examined whether participation in military combat affects post-military health and social adjustment of soldiers regardless of their initial reactions. It also examined the relationship between pre-military variables and the risk of combat exhaustion in both the short and long run.

Kettner compared 1082 Swedish combat veterans serving in UN battalions in the Congo with 1242 non-combat Swedish UN soldiers. Data were collected on morbidity, income, and alcohol offenses during the years preceding the UN service as well as during the 3-4 years after service. Combat veterans did not differ from non-combat veterans in physical or psychiatric morbidity after their UN service. Furthermore, they did not differ from non-combatants in the number of alcohol offenses after UN service. On the other hand, combat veterans were significantly more prone to accidents and had a significantly lower income than the non-combat veterans.

Kettner also examined 70 Swedish UN soldiers with and without combat exhaustion, controlling for combat exposure (Table 2). With the exception of meticulousness, there were no significant differences between groups.

Table 2. Frequency of endorsed symptoms for soldiers with and without combat exhaustion.

Symptom	With (N=35)	Without (N=35)	
Extreme fatigue	51.4%	62.9%	NS
Nervousness	34.3%	22.9%	NS
"Nervous stomach"	45.7%	60.0%	NS
Sleep disorders	28.6%	22.9%	NS
Tendency to worry	45.7%	34.3%	NS
OCD-traits	20.0%	28.6%	NS
Meticulousness (anxiousness)	5.7%	28.6%	$p<0.05$

Pre-military variables i.e., age, family psychiatric history, marital status, and lower intellectual functioning were associated with psychiatric breakdowns. Men under 21 suffered from combat exhaustion significantly more than older soldiers (Table 3). The long-term follow-up did not show that combat exhaustion worsens the social or medical outcome.

Table 3. Acute psychiatric combat reactions in 12th and 14th battalions in UN service in Congo, 1961.

Age	N=	Psychiatric breakdown in per cent
17-20	220	6.8%
21-24	474	2.5%
25-28	178	1.7%
29-32	89	4.5%
33-	121	0
Total	1082	15.5%

Table 4. Self-rated symptoms and reactions related to peacekeeping stress.

Item	UNIFIL/Hospital (N=340)	UNFICYP (N=605)	UNIFIL/Gulf War (N=459)	SA01 (N=368)
Depression	9.4	8.6	6.6	7.5
Sleep disturbance	7.1	6.6	5.5	1.7
Nightmares	1.2	1.5	1.3	-
Anxiousness/ restlessness	10.6	13.7	16.7	1.2
A need for isolation	24.1	16.2	-	2.8
Unpleasant feelings at work	7.1	7.6	18.7	-
Muscular tension	1.5	1.2	1.5	-

Table 5. UNIFIL/Hospital, UNFICYP, and UNIFIL/Gulf War reactions to UN peacekeeping service.

Item	UNIFIL/Hospital (N=340)	UNFICYP (N=605)	UNIFIL/Gulf War (N=459)
Subjective estimation of "personal nervous break down"	5.6	0.5	0
Possibilities for personal support	82.9	77.4	-
Too high use of alcohol (self rated)	24.7	9.6	3.5
Considered leaving UN-service	19.2	9.0	-
Feelings of monotony at work	51.3	63.6	40.7
Homesickness for age-group 20-29	53.1	30.7	52.2

The mission for the UNIFIL hospital in Naqoura, a few kilometers north of the Israeli border, is to provide the UN forces (5000-6000 soldiers) with hospital care and specialized medical services. Three contingents (N=340) have been studied by means of questionnaires, self-rating scales, and personal interviews during a three year period. The personal interviews were structured and performed in the last month of service for each contingent. All the interviews took place within the Swedish UN hospital area in South Lebanon (2). A study of mental adjustment was carried out by means of a questionnaire with one Swedish UN logistic battalion in South Lebanon at the end of its period of service (3). Though the results suggested a generally good adjustment, the frequency of stress-related symptoms was relatively high. Some respondents experienced the service as being monotonous.

In addition to this study, two Swedish rifle battalions serving as UN-soldiers in Cyprus (UNFICYP) have been investigated with respect to pre-military variables, motives for application for UN service, as well as stress-related symptoms. The comparison of these separate investigations are presented in Tables 4 & 5. The findings suggest that very few interviewees experienced "personal nervous breakdown" (0.5%). In general, the soldiers reported very few psychological or psychosomatic complaints in the short run. There seemed, however, to be two groups of persons at risk, namely those who were repatriated and those with a high consumption of alcohol (4).

Furthermore, the soldiers of one Swedish logistic battalion were deployed to the Gulf War during the last month of their mission in South Lebanon. A representative sample was studied using the same methodology as these other studies. The results have not yet been published, but there seemed to be no differences with previous findings.

Finally, 363 UN soldiers were assessed at a Swedish-run field hospital (SA01) during the Gulf War, for the acute treatment of combat injuries. The hospital was located in Saudi Arabia. Towards the end of the mission, the frequencies of stress-related symptoms were assessed using the same methodology administered in the earlier studies. As depicted in Table 4, remarkably low frequencies of symptoms were reported.

Practical and Clinical Aspects

Conclusions from Kettner's (1) study suggest that personality factors do less to cause mental breakdown during battle than they do in other circumstances of military life. Kettner's findings also suggest that the soldiers should be older than 21 years of age. The interviewed health care personnel of three Swedish UNIFIL contingents had different backgrounds and experiences. Although the data presented here inidcate

To witness the effects of a massacre on innocent civilians - and not being capable to prevent or retaliate, might result in intense traumatic stress reactions.

that stress reactions were not common and that a great many soldiers wanted to continue their UN service (2), it should be noted that different background experiences coupled with primitive living accomodations and heightened worry about significant others while in the service may still be significant stressors. Furthermore, in all three groups, there were persons at risk (e.g., cases of repatriation and heavy drinkers), who might develop psycho-social problems or psychiatric disorders with a delayed onset (4). As a result of the work reported here, we have identified a number of cognitive and emotional variables that may serve as stressors for peacekeeping soldiers (Table 1).

In order to prevent physical, mental or social after-effects among Swedish military personnel in UN-service in Bosnia-Herzegovina, the demobilization procedure was revised and expanded. Before 1994, the demobilization procedure (in general) consisted of a short program, with an emphasis on logistic and administrative end-of mission routines. In 1994, the procedure was extended to include stress debriefing, an official ceremony, and home-coming information about the physical and psychological stress-mechanisms. Furthermore, a post-demobilization psychosocial support system has begun to develop.

References

1. Kettner, B. (1972). Combat strain and subsequent mental health. A follow-up study of Swedish soldiers serving in the United Nations forces 1961-62. *Acta Psychiatrica Scandinavica*; Suppl 230.
2. Lundin, T., & Otto, U. (1989). Stress reactions among Swedish health care personnel in UNIFIL, South Lebanon 1982-1984. *Stress Medicine*, 5, 237-46.
3. Calstrom, A., Lundin, T., & Otto, U. (1990). Mental adjustment of Swedish UN soldiers in South Lebanon in 1988. *Stress Medicine*, 6, 305-10.
4. Lundin, T., & Otto, U. (1992). Swedish UN soldiers in Cyprus, UNFICYP: Their psychological and social situation. *Psychotherapy and Psychosomatics*, 57, 4, 187-93.
5. Westling, G. (1995). Swedish UN-personnel demobilization procedures and support apparatus: Experiences, limitations and possible development. Presentation at the *4th European Conference on Traumatic Stress*, Paris.

Tom Lundin and Ulf Otto are at the Department of Psychiatry, Karolinska Hospital, Box 1366, S-172 27 SUNDYBERG, Sweden.

!!!!!!!! ATTENTION: VA and VET CENTER STAFF !!!!!!!!

PTSD ARTICLE LIBRARY

The Clinical Laboratory and Education Division of the National Center maintains a small but helpful library of key articles on various aspects of PTSD. If you work in the VAMC or Vet Center systems and would like to receive articles on a particular topic, please contact Gloria Galavez at:

Telephone: FTS 463-2673 (Commercial: 415-493-5000 X22673)

e-mail: jir@iserver.icon.palo-alto.med.va.gov

Address: National Center for PTSD
Attn: Education
VA Palo Alto Health Care System
3801 Miranda Ave.
Palo Alto, CA 94304

Please limit your requests to no more than 3 of the following topic areas:

- Assessment of PTSD
- Chaplaincy and PTSD
- Child Abuse
- Cross-Cultural Issues in PTSD Treatment
- Disaster Mental Health
- Exposure/Focus Treatment
- Grief and Loss
- Nursing and PTSD
- Psychobiology of PTSD
- PTSD Overview
- Spirituality
- Substance Abuse and PTSD
- Therapist/Staff Care
- Treatment of PTSD
- Women: Rape and Combat Trauma

We hope that this service is helpful!!!

PEACEKEEPER STRESS: NEW AND DIFFERENT?

Lars Weisaeth, M.D., Ph.D., Lars Mehlum, M.D., Ph.D., & Mauritz S. Mortensen, M.A.

Lars Weisaeth, M.D., Ph.D.

Lars Mehlum, M.D., Ph.D.

Mauritz S. Mortensen, M.A.

Since its foundation after World War II, the United Nations has organized and implemented 34 peace-keeping/making missions in 40 countries on four continents. Norway, a sub-arctic country with a population of four million, has sent military troops (a total of about 50,000 over a period of nearly 50 years) to participate in 15 of these operations. Thirty-seven Norwegians have been killed while in service. The United Nations Interim Force in Lebanon (UNIFIL), initiated 1978, is by far the largest operation in which more than 25,000 Norwegian men and women have served so far.

Clinical impressions (1) had made it clear that serving as a UN peacekeeper might have serious personal consequences for health and well-being. The need for more systematic empirical data led to the initiation of the UNIFIL study (2). Started in 1990, it was the first comprehensive scientific investigation of its kind. The work has been carried out by the Division for Disaster Psychiatry, Joint Medical Services, Norwegian Defense Headquarters in Oslo.

Design

Between 1978 and 1991, a total of 15,931 men and women served in the Norwegian units, mainly NORBATT, and HQ Staff Officer positions, adding up to 20,878 six-month terms. The study is a follow-up survey conducted 6.6 years on the average after each soldier's conclusion of service term in UNIFIL. The sample consists of three sub-groups. To attain representation of the entire population (all contingents and units within the contingents), a stratified sample of 1,062 individuals was drawn from the total of 15,931. Of these, 724 agreed to be interviewed (a response rate of 68.2%). This sub-group was labeled the Cross-sectional Group (CSG). A second sub-group was made up of soldiers who had their service interrupted before the end of the term (SIBT), due to medical (29.5%), social (40.0%) or disciplinary (29.5%) problems, and were repatriated. In this group 59.7% consented to be interviewed. A third group was a sample of "unrepatriated" matched controls for each of the SIBT subjects (equal in age, rank, contingent and position).

Methods

Data for the UNIFIL Study has been gathered by means of survey questionnaires, personal interview and national demographic registers. A 67-page questionnaire was mailed to every individual in the samples, presenting a wide range of questions covering 20 main areas. Some results from the study will be presented below, focusing on characteristic UNIFIL variables such as motivation for the service and self-evaluation of individual experiences, including positive vs. negative after-effects, and stressful experiences.

Results

The majority (89.9%) of the Norwegian UN soldiers (CSG) were reservists on time-limited (3-6 months) contracts. As a small nation with limited manpower resources, Norway practices a system with 12-18 months compulsory military service for all males, voluntary for females, followed by 25 years of reservist status with refresher training and maneuvers, a total of 575 days of compulsory military service for men. Peacekeeping service is voluntary, and not included in the total compulsory.

The UNIFIL sample consisted mainly of young men (mean age 26.5 years). More than half of the sample served for two or more six-month terms. It should be kept in mind that Norwegian men have often been used to serve for long periods outside the national borders, especially in the Merchant Navy which for many years had up to 60,000 men on 3,000 ships plowing all oceans. For young men to leave home and serve in foreign environments has been customary for 150 years. With the number of jobs in the Merchant Navy declining, peacekeeping could be looked upon as a substitute.

Motives for Volunteering

Various motives were given for seeking UNIFIL service. Common reasons included to seek new experiences, excitement and danger (sensation-seeking), as was financial gain, since this type of service is well paid compared to work in the home environment. Half of the interview subjects reported that they felt attracted to a military life-style, familiar to them from their compulsory service. Some wanted to qualify for a later military or civil career through the experience acquired in UNIFIL service. A considerable proportion said they wanted to contribute to peace, and obtain insight into the Middle-East conflict pattern, by going there and seeing for themselves. Relatively few entered the service in order to flee from domestic problems or merely to get a job. The majority of these motives--from sensation-seeking and practically-oriented motives to idealistic and altruistic motives-- can be considered socially acceptable. One might argue that adventure and sensation-seeking might be less desirable motivations, however, no significant relationship was found between these types of motives and possible negative outcomes.

Self-Perception

How then, did the UNIFIL personnel perceive their own mission and evaluate their role as peacekeepers? The answers were elucidated through a series of semantic differential scales. The majority felt that they had managed to maintain a neutral position in face of the conflicting parties. Most believed their personal contribution as part of the UN force to be important for securing peace in southern Lebanon. Some doubt

was voiced, however, as to whether the UN interim force really had made a contribution to solving the conflicts in the area. Nearly all felt that to be able to communicate well with the local population and building up mutual confidence between the conflicting parties was very important for the international peacekeeper. Opinions were more divided over the questions of whether UN personnel should use more military force, and whether the role as professional soldier ought to be emphasized more strongly.

As the saying goes, the traditional soldier expects war and gets peace, whereas the UN peacekeeper expects peace and gets war.

Atrocities

Witnessing atrocities against civilians without opportunity to help, and being subjected to firing incidents without permission to return fire, seem to represent especially severe traumas typical for the peacekeeper in contrast to the traditional combat soldier. One Norwegian soldier was taken hostage and equipped with a necklace of unsecured hand-grenades. Over several days he was threatened and made to believe that he was going to be killed. Among soldiers who have had these kinds of experiences, quite a few developed serious mental problems in the aftermath.

Dilemmas

Although peacekeeping soldiers are different from a traditional soldier in that they are not supposed to take sides or try to solve problems by using fire-power against one or more of the conflicting parties, those interviewed reported that they frequently experienced hostility from various armed parties. In this respect, the peacekeepers really served as a buffer. The uneasy feeling of being used as a punching bag might be strong especially among combat-trained infantrymen who have their role of neutrality put to test.

Well aware of the peacekeeper's limited opportunity to retaliate, conflicting parties sometimes submit the peacekeepers to various forms of harassment, thereby compromising their mission. More cruel forms of provocation include captivity and isolation from soldier's unit. Forcing peacekeepers to witness atrocities against children, women and elderly represents another form of traumatic experience.

Positive Outcomes

As the saying goes, the traditional soldier expects war and gets peace, whereas the UN peacekeeper expects peace and gets war. Obviously, many of the Norwegian peacekeepers in southern Lebanon had not expected to face what they actually did. Despite the stressful events and traumatic experiences many had to face, however, the vast majority of the soldiers carried away a positive main impression of the service and the environment. Quite a few reportedly felt that their experiences had expanded their horizon to the problems tormenting the population in the region. Many believed that their stress-tolerance and self-reliance had been enhanced, important elements in processing stressful experiences. Having acquired new military skills, the majority said they would recommend similar types of UN service to a friend or even their son or daughter.

Health Problems

What consequences did the service have for the personnel in the follow-up period with regard to health and well-being? Special attention was paid to the soldiers who had been repatriated before the end of their term, the SIBT group. As 96.7% of all servicemen completed their term as planned, this group consisted of a mere 3.3%, or 530 individuals. Repatriation varied somewhat among the 26 contingents. They were rather frequent at the start of the mission, and have almost disappeared as a problem in more recent years.

PTSD

The Post-traumatic Symptom Scale (PTSS--10) was used to gauge the prevalence and intensity of core symptoms of PTSD (3). In the CSG, five percent were found to be PTSD cases (defined as a total score above six). The SIBT group, however, showed 15% prevalence of PTSD. If those with scores 4-6 are included in this case-group, there is a PTSD prevalence of 25.6% in the SIBT group. The relative risk of PTSS-10 in the SIBT-group compared to the control group was found to be 3.5.

A considerable proportion of the SIBT-group (48.8%) as well as the cross-sectional sample (44.6%) increased the consumption of alcoholic beverages during the service term. The explanation seems to be closer linked with increased availability and low prices that to need due to nervous tension or work overload. One sub-group, well represented in the SIBT-group, did not manage to adjust alcohol intake upon return home, and continued to consume more alcohol than before entering UN-service.

Accident Risk

Further problems following the UN-service included unemployment, deteriorating financial status, legal prosecution, major accident and divorce. Whereas there was no significant difference between the SIBT-group and the control group before the service with regard to unemployment, prosecution and accidents, the differences had increased considerably on these variables at the follow-up. Financial problems and divorce were over-represented in the SIBT group before service commenced. At the follow-up, however, one third of the SIBT group, twice as many as in the control group, had experienced longer periods of unemployment. Financial problems seem to follow in the wake of unemployment. Twelve per cent (12%) of the SIBT group, two to three more times than in the control group, answered in the affirmative when asked whether they had been exposed to one or more serious accidents during the follow-up period. Divorce was twice as common in the SIBT group as for the controls. Even legal prosecution turned out to be more common in the SIBT group.

Suicide

The question of mortality may serve as an ultimate measure of possible noxious effects of the UN experience. The most severe short- and long-term consequence of serving in the UN peacekeeping forces is

suicide and suicidal behavior. Earlier studies have shown that although suicide rates tend to decline during war-time, they may increase in the aftermath. Some Vietnam War-related studies (4) have pointed at this development. Although the conditions prevailing in the UNIFIL service cannot be compared with the dramatic Vietnam War situations, some health professionals and particularly the mass media have claimed that numerous suicides may have occurred in the UNIFIL personnel during or after service. To examine this concern, a study of the national registers was conducted to determine the number of deaths, time of death and causes of death. A 100% trace rate was obtained.

Results showed that a total of 172 individuals (of the 15,931 who had served in UNIFIL) had died in the relevant period of time. These cases were distributed in three categories and the figures were compared with expected figures in the same cohort in the total population, gathered from the Census Bureau (Table 1).

Table 1. Comparison of types of death in UNIFIL veterans and a matching cohort of total population.

Type of Death	UNIFIL veterans	Matching cohort total population
Natural illness	68	113
Violent/accidental death	104	77.4
Suicide	45	32.1
Total deaths	172	190

The total number of deaths in the UNIFIL veteran group was lower than the expectancy, due to the lower number of natural deaths. After all, this personnel had been selected on the basis of fitness for service. The number of violent deaths was clearly higher, however, and the suicide figure was somewhat higher. The explanation may be two-fold. Either the UNIFIL experience was so stressful that it would explain the results, or there might have been a pre-selection of accident-prone individuals, some of whom may have been suicidal. Further understanding would require a psychological autopsy of each case.

Earlier military studies (5) have found that soldiers may be accident-prone for a period after having survived combat. Findings in the SIBT group and the relative high numbers of accidental deaths would seem to support this hypothesis. On the other hand, accidental deaths might be entirely or at least in part a result of the selection process, in that sensation-seeking risk-taking individuals might be attracted to UNIFIL service, and thus become over-represented in this population. This would be in accordance with the most common motive for enlisting, namely to seek danger and excitement.

Other Studies

In recent years, a number of studies have addressed problems related to peacekeeping service. Segal et al. (6) found that combat-trained light US infantry were not optimally suited for peacekeeping operations in Sinai. Action-oriented soldiers forced into passive role-performance tended to develop frustration. Similar problems may have been at work in Somalia. A Dutch follow-up study (7) found that 5% of their former UNIFIL soldiers suffered from psycho-social problems several years after the Netherlands withdrew their contingent, a finding corresponding well with the Norwegian UNIFIL study. Swedish studies of medical and logistics personnel in UNIFIL (8) found that stress reactions were not prominent. During service in UNFICYP in Cyprus, only 0.5% of the Swedish personnel suffered from nervous breakdown (9). Among Danish personnel in ex-Yugoslavia, 30% showed some level of post-traumatic stress response, while 7% had severe symptoms (10). Also among Canadian soldiers serving in UNPROFOR in ex-Yugoslavia, relatively high rates of post-traumatic stress symptoms have been reported (11). French studies (12) of 40 psychiatric cases, of which 38 were from ex-Yugoslavia and two from Somalia, recorded anxiety disorders related to the experience of sniper-fire with the insecurity of being a living target. After their service in Somalia, 25.7% of US combat-trained soldiers qualified for the PTSD criterion of traumatic re-experience (13). A total of 11.4% met PTSD criteria according to present US diagnostic categories. The best predictors of PTSD were high magnitude stressor events such as *rocks thrown at unit* (76%), *unit fired upon* (65%), *rejected by Somalis when trying to help* (56%), and *frustration with peacekeeping*. Highly motivated German medical soldiers serving in three contingent's in UNTAC in Cambodia during 1992-93, were found to have low prevalence of psychological after-effects (14). A study of 56 Norwegian UN observers mostly serving in ex-Yugoslavia (15) identified several stressors. Among the more severe stressors were lack of military structure, multi-national teams, disparity between age and military rank, the task of investigating civilian casualties including searching for bullets in dead bodies, and the experience of being shot at when unarmed.

...A number of initiatives have already been taken to reduce the risk of personnel developing post-traumatic stress disorders and other health hazards during and after peacekeeping service.... These include improved selection procedures, education and training, and psychosocial support measures offered to personnel pre-deployment, during the operations, and after completion of the term.

Conclusion

Although the main impression from the UNIFIL study is that the vast majority of personnel cope relatively well with the challenges presented by service in southern Lebanon, some individuals have problems. It is an

important task to analyze the data in order to be able to develop selection procedures which may serve to minimize the number of risk-cases. Based upon the results of the present study, a number of initiatives have already been taken to reduce the risk of personnel developing post-traumatic stress disorders and other health hazards during and after peacekeeping service, and to prevent suicide. These initiatives include improved selection procedures, education and training, and psychosocial support measures offered to personnel pre-deployment, during the operations and after completion of the term.

References

1. Weisaeth, L. & Sund, A. (1982). Psychiatric problems in UNIFIL and the UN-soldier's stress syndrome. *International Review of the Army, Navy and Air Force Medical Services, 55*, 109-116.
2. The UNIFIL Study 1991-1992. (1993). Report - Part I. Results and recommendations. HC Defense Command Norway. *The Joint Medical Service, 25*, (2).
3. Raphael, B., Lundin, T., & Weisaeth, L. (1989). A research method for the study of psychological and psychiatric aspects of disaster. *Acta Psych Scan Suppl., 353*, 80.
4. Kramer, T.L., Lindy, J.D., Green, B.L., Grace, M.C,. & Leonard, A.C. (1994). The comorbidity of post-traumatic stress disorder and suicidality in Vietnam Veterans. *Suicide and Life-threatening Behavior, 24*, 58-67.
5. Kettner, B. (1972). Combat strain and subsequent mental health. A follow-up study of Swedish soldiers serving in the UN forces 1961-62. *Act Psychiatry Scand Suppl*, 230.
6. Segal, D.R., Furukawa, T.P., & Lindh, J.C. (1990). Light infantry as peacekeepers in the Sinai. *Armed Forces and Society, 16*, 385-403.
7. Knoester, J.P. (1989). Traumatische ervaringen en ex-Unifil militarien. Een literatuur - en dossierondeizoek Doc nr GW 89-12. Doctoralscriptie, Vrije Universiteit, Amsterdam.
8. Lundin, T., & Otto, U. (1989). Stress reactions among Swedish health care personnel in UNIFIL 1982-84. *Stress Medicine, 5, 237-246.*
9. Lundin T., & Otto, U. (1992). Swedish UN soldiers in Cyprus: Their psychological and social situation. *Psychotherapy and Psychosomatics, 57*, 187-193.
10. Madsen, J.P. (1995). Stresspavirkning under FN-tjeneste. *Militaert Tidsskrift*, (1), 4-10.
11. Passey, G. (1995). Psychological consequences of Canadian UN Peacekeeping Duties in Croatia and Bosnia 1992-93, in IV E.C.O.T.S: Fourth European Conference on Traumatic Stress, Pairs, May 7-11, 1994, p. 108.
12. Doutheau, C., Lebigot, F., Moraud, C., Crocq, L., Fabre, L.M., & Favre, J.D. (1994). Stress factors and psychopathological reactions of UN missions in the French army. *International Review of the Army, Navy and Air Force Medical Services 67*, 36-38.
13. Friedman, M., & Ehlich, P. (1995). Psychological sequelae associated with UN Peacekeeping Operations in Somalia, in IV E.C.O.T.S: Fourth European Conference on Traumatic Stress, Paris, May 7-11, 1995, p. 56.
14. Schueffel, W., Schade, B. (1994). Erste Ergebnise der Untersuchung zur Belastung und der Stress reaktionen von Sanitaetspersonal im humanitaeren Hilfseinsatz in Kambodscha, Marburg.
15. Herlofsen P. & Kristiansen H: Personal communication, 1995.

Lars Weisaeth, Lars Mehlum, and Mauritz Mortensen work for the Division of Disaster Psychiatry, Joint Medical Services, Defense Headquarters, in Oslo, Norway.

NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.
Executive Director, NC-PTSD

I'd like to focus this column on our education program. National Center education initiatives are designed to improve knowledge and skills of practitioners and scientists, to disseminate innovations in care, and to create a process through which clinical practice is informed by new theoretical developments and results of empirical research.

The challenge at the outset was to create an educational program that could reach the maximum number of clinicians and researchers and that could be managed within our existing budget. As a result, the mainstays of our educational program are newsletters, the Internet, telephone conferences, and the Clinical Training Program at Palo Alto. Our program is guided by a steering committee chaired by Fred Gusman and consisting of Ray Scurfield, Joe Ruzek, Julian Ford, Sarah Miyahira, and myself.

Our two newsletters, *NCP Clinical Quarterly and PTSD Research Quarterly* each have a circulation of approximately 5,000. The *NCP Clinical Quarterly,* edited by Bruce H. Young at Palo Alto, is primarily for clinicians. Each issue contains contributions from national and international experts in treatment and research on a special theme. Last year, for example, issues included: PTSD and Women Veterans; Spirituality and PTSD; Grief and Bereavement (including the emotional response to disaster); and Key Issues in PTSD Treatment. In other words, the *Clinical Quarterly* represents our best effort to keep clinicians up-to-date on the latest developments in treatment and research on PTSD.

The *PTSD Research Quarterly*, edited by Paula Schnurr at White River Junction, has a complementary focus. It is published for researchers, scholars and interested clinicians. It is a guide to the latest scientific literature on a specific topic. For example, in the last year the *Research Quarterly* focused on Crime-Related PTSD, Holocaust Survivors, Memory and Trauma, and Information Processing and Trauma. Each issue is guest-edited by a noted expert(s) in that particular field. The *Research Quarterly* draws upon the National PTSD Resource Center in White River Junction, VT, and its' PILOTS database. PILOTS (Published International Literature On Traumatic Stress) is a computerized bibliographic database that has now indexed over 9,200 scientific articles, chapters, and books concerned with PTSD and related topics. Since PILOTS is mounted on the Dartmouth College On-Line Catalog, it is available to anyone with a personal computer who can access the Internet. PILOTS was created by Fred Lerner and has emerged as the most comprehensive and user-friendly bibliographic database in the trauma field.

A new project, recently launched by Fred Lerner, is a National Center Homepage on the World Wide Web of the Internet. This web site is available to traumatic stress researchers, clinicians, and students worldwide. It offers information on the National Center and its seven divisions, interactive searching of the PILOTS database, back issues of the *PTSD Research Quarterly* and links to other Internet resources on PTSD. The Internet address for our Homepage is **http://www.dartmouth.edu/dms/ptsd/**

The monthly telephone conference calls are a key aspect of our educational program. As part of Bob Rosenheck's regularly scheduled conference calls to staff of all outpatient and inpatient departments, Joe Ruzek has coordinated educational calls on topics such as Psychosocial Debriefing of Operation Desert Storm Veterans, Transition Houses and PTSD Community Aftercare, Treatment of Nightmares in Combat-Related PTSD, Childhood Trauma Issues in Military-Related PTSD, and Disaster Mental Health Interventions.

Our most successful hands-on training program continues to be the week-long intensive Clinical Training Program at Palo Alto. This program focuses on inpatient, outpatient, and community aftercare treatment for chronic military-related PTSD. Seventy-five PTSD and health care clinicians from around the country completed the training last year. This program is very popular and has continued to grow since it began. Although most trainees are VA hospital-based clinicians, Vet Center counselors, non-VA professionals, and distinguished international experts have also spent a full week at Palo Alto participating in this training.

A major new educational initiative is the development of a curriculum for training clinicians and administrators in disaster mental health interventions. This activity is part of the National Center's involvement in a national mental health disaster plan. Bruce Young, Julian Ford, and Joe Ruzek served as trainers with teams of VA mental health and PTSD clinicians in the May 1995 Federal Disaster Exercise. We expect that there will be more training activities regarding disaster mental health in coming years. Those are our most conspicuous activities. We also provide educational resource materials and services such as: a library of treatment manuals, an audiotaped PTSD lecture series, and a library of assessment and program evaluation instruments. In addition, National Center professionals carry out many training activities on an individual basis such as clinical and research supervision, participation in educational conferences, invited lectures at professional meetings, and consultation on clinical, research, and administrative matters.

As we plan for the future, we intend to maintain a specific focus on training activities concerning post-traumatic assessment and treatment of women, ethnic minority veterans, and disaster survivors. We also plan to develop patient education materials designed to meet the needs of our veteran customers as well as educational products for professionals in the primary care setting. Finally, we intend to remain responsive to the needs of veterans and clinicians alike and to support them through our various educational activities.

PRACTITIONER NETWORK

Julian Ford, Ph.D.
Deputy Executive Director for Education and Clinical Networking
NC-PTSD, White River Junction, VT

Trauma Networking Update: The continuum of care developed by DVA PTSD Programs

The model for networking and continuity of care in trauma services developed over the past 10 years by VA Medical Center and Vet Center programs in the Pacific Northwest offers validation for the many other PTSD programs to explore avenues for achieving coordinated care across the spectrum of sites and services related to caring for survivors of psychological trauma. As Mike Maxwell of the Portland VA Medical Center described on National Specialized PTSD Program conference call in October, and in an article in the last issue of the *Clinical Quarterly*, networking and establishing a true continuum of care means not just talking occasionally with referrers and aftercare providers, but also establishing a variety of dependable, ongoing, personal channels of communication for:

* Meshing the requirements and services provided by programs offering different types and intensities of PTSD care (e.g., Vet Centers, PCTs, WSDTTs, SUPTs, EBTPUs, SIPUs);
* Working closely with clinicians and programs providing care for co-morbid psychiatric and psychosocial conditions (e.g., Substance Abuse Units, Mental Health Clinics, General Psychiatric Inpatient Units, Homeless Domiciliaries);
* Providing consultation to clinicians and programs providing care for chronic medical conditions (e.g., Nursing Home Care Units, Rehabilitation Medicine, Geriatric Teams);
* Providing consultation to clinicians and programs providing primary healthcare (e.g., Primary Evaluation Clinics, Women's Health Clinics, Cardiopulmonary Clinics);
* Providing direct or indirect (via Psychiatry Consultation and Liaison, or Social Work specialists) consultation to critical care clinicians (e.g., Emergency Room/Admitting Office);
* Networking with social service providers outside the VA (e.g., Veterans Employment Specialists, community Housing Authorities, Veterans Service Officers);
* Networking and developing collaborative programs with self help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous);
* Maintaining an active presence on training committees that place residents, interns, and practicum students within the VA Medical Center.

Is there enough time to establish and nurture all of these critical connections? At first glance, the answer is probably "No!" Every PTSD program clinician has a primary responsibility to evaluate and treat veterans with military-related PTSD, and to meet workload requirements week-in and week-out. The better answer is that, although no clinician and no program can do it all, keeping these channels of communication open and in active use can be a tremendous time-saver and may be the only way to truly achieve a continuum of biopsychosocial care for each client. Crises can be prevented or anticipated, "splitting" can be identified before it becomes a source of interprofessional conflict, therapy groups get started that otherwise might languish, psychoeducational materials get shared, program boundaries get strengthened yet made more helpfully permeable, providers outside the program and outside the VA are treated as members of the team (and vice versa), community resources get accessed (e.g., volunteers, trainees, endowments and donations for special projects), and clinicians get additional opportunities to debrief and provide mutual support.

Who's doing this kind of creative outreach and integration? Most, if not all, specialized PTSD programs and Vet Centers, as well as most Psychology, Psychiatry, and Social Work programs.

How many of these networking efforts are going forward with few accolades and little formal recognition? Again, and this time unfortunately, the answer is "most!"

What can we do about this? Two things, in the short run. First, the consortia of programs that are already underway in different areas of the country deserve our attention and respect. In addition to the Oregon/Washington PTSD Coordinating Committee, I have been contacted by VA PTSD program directors who are chairing or contributing to VA/RCS PTSD program networks in New England (Drs. Karen Krinsley and Lisa Fisher), New York (Dr. William Chamberlin), Pennsylvania (Drs. Ann Wilson and Ed Pontius), Louisiana (Dr. Madeleine Uddo), and Ohio/Kentucky (Dr. Tamara Miller). These networks can be a model and a resource for all of us. I will be highlighting them in future issues of the *Clinical Quarterly* so that we may all benefit from their innovations. Please call (FTS: 700-829-6071) or e-mail me to tell me of your network (Julian.Ford@Dartmouth.edu).

Second, we can grasp the opportunities that the VA's reorganization into Veterans Integrated Service Network (VISNs) offers. Each VISN's executive director and management team formally determines the organizational structure through which decisions about program composition, staffing, and funding will be taken. Within each VISN, a Mental Health Advisory Committee will specifically oversee the revision and development of all mental health services. PTSD programs can coordinate to provide a seamless network of trauma-related clinical services (i.e., outreach, screening, evaluation, assessment, education, short-term treatment, supportive treatment, case management, aftercare). Linkages among programs across geographic sites, service lines, and organizational boundaries (e.g., Medical Center hospital programs, satellite Clinics, Vet Centers, community resources) are precisely what the VISN model prescribes, to reduce redundancies and to assure continuity of care with shrinking resources.

Cost efficient continuity of patient care, our primary mission, is enhanced not only for PTSD but also for trauma screening, consultation, and education in mental health, substance abuse, rehabilitation medicine, emergency medicine, and the array of primary healthcare clinics. Input to management and Mental Health Advisory Committee decisions can be made efficiently on behalf of a multi-program and multidisciplinary practice specialty (i.e., care for veterans who have experienced psychological trauma) rather than piecemeal from isolated program. Collaborative projects involving VA programs and community resources can be developed. For example, an alliance can be forged by a consortium of PTSD programs with Veterans Service Organizations, Veterans Employment Specialists, and local Housing Authorities to co-sponsor transitional community housing for veterans upon discharge from inpatient or residential PTSD treatment. Requests for training programs can be developed for RMEC sponsorship, to meet the needs of, and bring together, clinicians from the entire PTSD program consortium.

I look forward to hearing from you about your networking strategies and activities!

WOMEN AND TRAUMA: A CLINICAL FORUM

Marylene Cloitre, Ph.D.

This report is sent to us by Dr. Monika Hauser, Director of Medica Zenica in Zenica, Bosnia. Dr. Hauser has been centrally involved in treating women traumatized during the Bosnian War and tells about her experience as a health practitioner and her perceptions of the international community's response to rape-related war trauma. The report is comprised of excerpts from her speech at the International Congress for the Documentation of Genocide in Bosnia that convened last year in Bonn, Germany. M. Cloitre

From the beginning of their forcible invasion and destruction of non-Serbian life in Croatia and Bosnia-Herzegovina, the Serbian aggressors have been using rape as a war strategy. We began to work in the women's therapy center Medica in Zenica, Central Bosnia, in April 1993, due to the Serbian and later the Croatian blockade, manned by the so-called Bosnian- Croatian defense council, the HVO. With access roads closed, all communication with the outside world was interrupted. The municipal hospital was in a desolate condition and often could only render first aid. At the worst time, in fall/winter '93, only 15-20% of the required supplies reached the starving population. For the refugees, their experience of direct violence in their home towns and in the internment camps was now followed by a kind of indirect violence owing to the lack of medical and psychological support.

The women who have been coming to us during the last 2+ years reflect the chronology of the refugee movement to Central Bosnia. All three ethnic groups are represented, though 95% of the women are Muslims. Up to the present day, we have been providing out-patient gynecological care to more than 12,000 women, out-patient psychological care to more than 500 women and in-patient psychological care to nearly 500 women and their children. The youngest female to receive treatment was an 8 year-old girl, the oldest, a 70 year-old woman.

These women described the brutality levied upon them in the detention camps: Each day women and girls would be chosen from the crowd and taken away to a supposed interrogation. Instead of interrogation, the women were taunted, beaten, and forced to have sexual intercourse with one or many soldiers at a time, sometimes within in a group of many women, and sometimes with objects. At times, the women were forced to penetrate one another with objects so as to cause visible pain. Often the women were raped and abused daily, a horror that could continue for weeks or months.

Nearly all 12,000 women who have been cared for in our gynecological out-patient department showed signs of gynecological diseases, including serious bleeding lasting months, infectious and sexual diseases, and disorders of the menstruation cycle. More than 95% of the women who conceived due to rape wanted an abortion. These women also suffered a myriad of physical health problems and typically experienced severe symptoms of post traumatic stress disorder.

Women were not only exposed to multiple rapes, but to many other forms of violence. In Zepce, a 40 year-old woman and her 18 year-old daughter fled from the shells of the HVO soldiers, escaping to a shelter. When a shell hit the shelter, the daughter's legs were torn off. She died some days later, without any help, in an agonizing manner. Her mother still suffers from obsessions and sometimes enters a state in whicb she can no longer feel her legs. If one regards the extent of violence, the relief measures have been grossly inadequate to address the short-term and long-term consequences from which women and children suffer.

Monica Hauser, M.D.

The awareness of rape as a weapon of war has itself become an instrument of war to the extent that it serves the interests of the war parties. For example, the governments of Croatia and Bosnia-Herzegovina have contributed a lot to bringing the mass-rapes to the public attention, but instead of condemning them, they have simply made them an instrument towards their own aims. The legitimate hope that the international community would intervene - if it actually saw the extent of these atrocities - quickly became an illusion. When the politicians in Zagreb and Sarajevo realized this, interest in war rape and for the surviving victims, ceased to exist. Medica's aim is to ensure that the subject of rape as a violent crime does not vanish from the public interest simply because, in the view of war or media strategy, it is no longer useful to simply condemn these atrocities.

Little consideration or action concerning war rape has been observed. In the summer of 1992, the International Red Cross already knew about the rape camps but there was no outcry to the people of the world. UNHCR, too, reacted only hesitatingly to the demands for systematic investigations. The important international relief organizations, who have the self-defined task and the task assigned to them by the international community to protect and care for the tortured population in war, were willing to help in only a few exceptional cases.

A recent example of the indifferent attitude towards violent crimes against women is apparent in the Amnesty report of August 13th, 1995, about the crimes in Srebrenica — the crimes executed against women are discussed in only two short sentences. Apart from the fact that the entire report absolutely plays down the events in Srebrenica and in Potocari it literally says: "Numerous witnesses told us that young women had been taken from the convoys. There are some concerns that there were individual cases of rape and sexual abuse."

The survivors of the violence must have a right to financial compensation, therapy, a clear state of residence and work in a safe land. Violations of UN-accepted public international law must be named and condemned. Sexual torture must be recognized as a reason to ask for political asylum. Rape must finally and explicitly be banned as a serious war crime in each military conflict. In this respect the regulations of the Geneva Conventions must be supplemented by the element of rape. Mechanisms must be devised which help women make statements and which protect them from stigmatization and economic and political persecution after this task is done.

In the midst of the Bosnian war, women and men of all ethnic groups here must realize and act on democratic values. Otherwise we must ask ourselves: How damaged is our society that we do not demand responsible action and allow the destruction of human lives?

Dr. Monika Hauser's address is Medica e. V.,Waisenhausgasse 65, 50676 Koln, Germany tel: 0049-221-9318980

PSYCHIATRIC TREATMENT OF SOUTHEAST ASIAN REFUGEES

James K. Boehnlein, M.D., M.Sc., & J. David Kinzie, M.D.

James K. Boehnlein, M.D., M.Sc.

Along with the soldiers, the Vietnam War has had long-term effects on the civilian populations of Cambodia, Laos, and Vietnam. Many refugees who left Southeast Asia after 1975 continue to re-experience and suffer from their war, escape, concentration camp, and prisoner-of-war experiences. They suffered great losses of family members, livelihood, and cultural traditions. Vietnamese saw family members killed, possessions confiscated, and villages destroyed. The Laotians, Mien, and Hmong had significant and irreversible damage done to their social structures and cultures. Cambodians experienced the brutal rule of Pol Pot from 1975-1979 when an estimated one million people died of disease, starvation, torture, and execution. No individual or family was spared, directly or indirectly, the trauma of this period.

After the war, many Vietnamese escaped to other countries of Southeast Asia via small boats on the high seas, braving hostile elements, pirates, and shortages of food and water. Cambodians fled to crowded refugee camps on the Thai border, where they often spent years in substandard and dangerous living conditions. Finally, millions of refugees were resettled throughout the world, especially in the United States, France, and Australia.

Besides coping with the memories of loss and trauma, these refugees faced pressures of acculturation such as employment and financial stressors, intergenerational change and reconciling traditional cultural values and traditions with those of the host country.

Indochinese Psychiatric Program

Our program at the Oregon Health Sciences University for psychiatric assessment and treatment of Indochinese refugees began in 1978 (1,2). Over the past 17 years, the clinic has treated more that 1000 refugees from Vietnam, Cambodia, and Laos (including ethnic Laotians, Mien, and Hmong), and 550 are currently enrolled in treatment. Clinic staff has grown to over 20 professionals, including 5 psychiatrists, a psychologist, a nurse practitioner, 3 masters of social work, and several licensed mental health counselors from each ethnic group represented in the clinic. Each psychiatrist heads his or her own treatment team, working with the counselor who is case manager for a specific group of patients. Patients are seen by their psychiatrist every one to three months for medication management and psychotherapy, and many have weekly group therapy (3) and participate in our Indochinese Socialization Center program to learn language, daily living, and work skills.

The most common diagnoses given to these patients are major depression and posttraumatic stress disorder (PTSD), most commonly together. Approximately ten percent of the patients meet diagnostic criteria for chronic schizophrenia, with much smaller percentages of patients receiving diagnoses of dementias or bipolar disorder. The highest percentages of patients with PTSD (over 90%) ae found among the Cambodian and Mien (4-6), and our clinic was the first to report the presence of PTSD among Cambodian refugees (7,8). We have found depression to be quite treatable initially and when it reoccurs, but like others (9-11), have also found that PTSD is more chronic and treatment resistant.

J. David Kinzie, M.D.

Research data are mixed in relation to the differential effects of pre-migration, migration, and post-migration trauma on subsequent refugee distress. Some have noted the primacy of premigration traumatic experiences such as war, torture, or family loss (12-14), but a number of factors in the host country can contribute to the reactivation of traumatic responses, such as exposure to crime, accidents, or anniversary reactions to traumatic events. The complexity of traumatic responses and the challenges of understanding them cross culturally can be difficult for even experienced clinicians. We take a biopsychosocial approach to assessment and treatment, including the effect of culture on the person's experience and understanding of their trauma within their own cultural and social system. The clinician must be aware of the historical and sociocultural heritage of each population with whom they work, and that includes an awareness of family and political structure, norms and values, and religious traditions. Since the recovery of a sense of purpose and meaning in life is a primary task of all trauma survivors regardless of ethnicity or culture, the clinician must be aware of specific cultural determinants of meaning, such as secular values and religious beliefs, that may affect psychotherapeutic interventions.

The complexity of traumatic responses and the challenges of understanding them cross-culturally can be difficult for even experienced clinicians. We take a biopsychosocial approach to assessment and treatment, including the effect of culture on the person's experience and understanding of their trauma within their own cultural and social system.

The effects of trauma and the refugee experience are both chronic conditions. From a treatment perspective, there is no short-term fix, and much of the time the comprehensive treatment of refugees must be considered long-term and supportive. A longitudinal relationship in patient care provides security and hope while individuals and families encounter the ups and downs of an often difficult life. As an example, the following is an outline of the key elements to our psychiatric treatment program for Southeast Asian Refugees.

Specific Treatment Elements

1. Education. Teaching patients about the effects of trauma and the fact that the majority of those who undergo severe trauma will have symptoms helps patients feel more accepted. It helps break down their self-perceived stigma of being "crazy."

2. Symptomatic relief of comorbid conditions. Depression is often present with PTSD. We have had a good experience with tricyclic antidepressants (e.g., imipramine, desipramine, and doxepin) and serotonin reuptake inhibitors (e.g., fluoxetine, sertraline, paroxetine). With the reduction of depression, nightmares and sleep disorders often improve.

3. Reduction of intrusive symptoms. We have found that clonidine often reduces irritability, startle reactions, and nightmares. We typically give it in conjunction with an antidepressant, but many patients take it alone. About half of our Cambodian patients are on clonidine and the rate of their acceptance of this medication is high.

4. Reduction of other stresses. Having the resources and staff to insure adequate finances, housing, and medical care gives great security to patients and reduces anxiety about the realistic concerns refugees often face.

5. Supportive psychotherapy. Predictable, empathic, reality-based ongoing psychotherapy with a psychiatrist every one to three months is a central element of our treatment model. Continued contact and appreciation of the refugee's experience and discussion of current issues and stresses are very affirming and comforting to the patients. Treatment sessions often include spouses and other family members. Modification of, and education about, medication is also accomplished in these sessions. Helping the refugee process current and past experiences, dream content, and difficulties in interpersonal relationships often reduces symptoms and enhances their perceived control and self-confidence. In addition, patients often see their primary case manager (a social worker or licensed mental health counselor) between clinic visits for supportive counseling sessions focusing on family problems or financial and housing issues.

6. Socialization groups. Group activities (led by Southeast Asian born mental health counselors) have been very useful in providing the patients with a sense of community and shared experiences. These usually are bi-cultural, including activities from the culture of origin, such as New Year's celebration, and sharing in American events such as Christmas and Thanksgiving. Practical matters of transportation, insurance, housing, and learning English are often discussed. Group therapy with a more process orientation has been conducted with Cambodian groups. The earliest themes that emerged, lasting up to two years, were related of the affect-laden Pol Pot trauma and losses. Another important theme has been the problems of raising children in America. An additional recurrent theme is related to aging and death, and the provision of appropriate ceremonies to ensure a good afterlife. With children less willing to follow traditional ways, patients feel that the necessary rituals will not be carried out. For parents, traditional expectations of respect from their children and deference to authority can conflict with the imposed reality of a more passive position due to illness or poor English language skills. Women in single parent families who have lost their husbands during war or migration are required to function as both father and mother. An important task may be to help each generation understand and accept each other's new beliefs and roles as the family evolves through the life cycle. The clinician must approach the family with respect for the strengths that allowed its members to survive individually and as a unit.

The effects of trauma and the refugee experience are both chronic conditions. From a treatment perspective, there is no short-term fix, and much of the time the comprehensive treatment of refugees must be considered long-term and supportive.

7. Indochinese Socialization Center. At a separate location, a socialization center has been developed to provide increased social activities and an expanded experience with American volunteers. This has been a popular activity with sharing of cultural traditions, and now has expanded to include vocational rehabilitation and job training.

8. Refugee opportunities to give back and participate. Throughout the treatment program, the refugees contribute in many ways. All the groups offer ethnic meals to the hospital staff at times of their culture of origins New Year's or other celebrations. Several groups (particularly the Mien) make craft items, such as embroidery, that represent their culture to the community. An advisory board for the Socialization Center includes many refugee members. The activities by the refugee patients are greatly appreciated by staff and undoubtedly increase the self-esteem of the patients.

The process of reconstructing meaning and purpose in life after trauma through bereavement is highly culturally determined, but the search for meaning itself and the struggle with grief ....are universal experiences for all groups of people who have experienced severe trauma.

Treating these traumatized patients has at times been difficult and the psychiatry staff has been greatly changed by the experience. Our countertransference feelings have been challenging and complicated (15). We have learned that assessment and treatment must always be offered within a broad context that integrates ethnocultural factors, problems of language, metaphors and symbols, and with an awareness of adaptation and acculturation pressures (16).

Some Closing Thoughts

The cross-cultural diagnosis and treatment of PTSD remains an area of opportunity and controversy. Not only must techniques, skills, and conceptual frameworks be available for evaluating a patient who may not share the same culture as the clinician, but diagnostic classification is a key step in pursuing cross-cultural factors related to epidemiology, etiology, prognosis, and treatment (17). Understanding the entire sociocultural milieu in which the patient functions is also crucial in distinguishing psychopathology from culture bound beliefs or behavior (18).

The process of reconstructing meaning and purpose in life after trauma through bereavement is highly culturally determined, but the search for meaning itself and the struggle with grief (which includes the reconstitution of self-concept and comfort in interpersonal relationships) are universal experiences for all groups of people who have experienced severe trauma. For example, although American veterans of the Vietnam War returned to their country of origin, many have struggled with issues that are analogous to bereavement in refugee groups - a loss of social structure, cultural values, and self-identity. Culturally constituted symbols, communication patterns, and healing approaches vary tremendously within the process of posttraumatic recovery, but cognitive disruption and existential pain remain a universal human response to traumatic events. The treatment of the broad spectrum of veterans in Vet Center therapy groups, of American Indian veterans with indigenous healing approaches, or of Southeast Asian refugees in socialization group settings all have a great deal in common through their focus on group healing in a social context.

As long as they are applied in the proper cultural context, biomedical interventions have the potential to diminish PTSD symptoms cross-culturally and can enhance and complement sociocultural interventions. For example, the treatment of insomnia and nightmares with medication can enhance daily functioning and improve subjective well-being, thus optimizing role functioning as spouse, parent, student, or employee. Reducing intrusive PTSD symptoms can allow the patient to benefit more fully from psychotherapy, tolerate interpersonal intimacy in his or her social environment, and participate in culturally sanctioned activities that enhance the grieving and recovery process.

Working with refugees who have experienced immense trauma is challenging for the clinician. A clinician's store of cultural knowledge should serve primarily as a general template against which an individual or family is assessed.

Although the DSM diagnostic criteria are severely limited in regard to placing illness or suffering in a sociocultural contest, they should not be limiting to the astute and experienced clinician. The DSM taxonomy is merely a scaffold upon which the clinician constructs a multilayered picture of the biological, psychological, and sociological effects of severe trauma upon the individual, family, and the culture at large. A therapeutic relationship within a biopsychosocial framework can serve as an important catalyst in assisting the traumatized refugee.

References

1. Kinzie, J.D., Tran, K.A., Breckenridge, A. & Bloom, J.D. (1980). An Indochinese refugee psychiatric clinic: Culturally accepted treatment approaches. *American Journal of Psychiatry, 137,* 1429-1432.

2. Kinzie, J.D., & Manson, S. (1983). Five-years' experience with Indochinese refugee psychiatric patients. *Journal of Operational Psychiatry, 14,* 105-111.

3. Kinzie, J.D., Leung, P.K., Bui, A., Keopraseuth, K.O., Rath, B., Riley, C., Fleck, J. & Ades. M. (1988). Group therapy with Southeast Asian refugees. *Community Mental Health Journal, 24,* 157-166.

4. Kinzie, J.D., Boehnlein, J.K., Leung, P., Moore, L., Riley, C. & Smith D. (1990). The high prevalence rate of PTSD and its clinical significance among Southeast Asian refugees. *American Journal of Psychiatry, 147,* 913-917.

5. Moore, L.J. & Boehnlein, J.K. (1991). Posttraumatic stress disorder, depression, and somatic symptoms in U.S. Mien patients. *Journal of Nervous and Mental Disease, 179,* 728-733.

6. Moore, L.J. & Boehnlein, J.K. (1991). Treating psychiatric disorders among Mien refugees from highland Laos. *Social Science and Medicine, 32,* 1029-1036.

7. Kinzie, J.D., Fredrickson, R.H., Rath, B. & Fleck, J. (1984). Posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry, 141,* 645-650.

8. Boehnlein, J.K., Kinzie, J.D., Rath, B., & Fleck, J. (1985). One year follow-up study of posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry, 142,* 956-959.

9. Sack, W.H., McSharry, S., Clarke, G.N., Kinney, R., Seeley, J. & Lewinsohn, P. (1994). The Khmer adolescent project: I. Epidemiologic findings in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 182,* 387-395.

10. Sack, W.H., Clarke, G.N., Kinney, R., Belestos, G., Him, C. & Seeley, J. (1995). The Khmer adolescent project: II. Functional capacities in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 183,* 177-181.

11. Sack, W.H., Clarke, G.N. & Seeley, J. (1995). Posttraumatic stress disorder across two generations of Cambodian refugees. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 1160-1166.

12. Carlson, E.B., & Rosser-Hogan, R. (1994). Cross-cultural responses to trauma: A Study of traumatic experiences and posttraumatic symptoms in Cambodian refugees. *Journal of Traumatic Stress, 7,* 43-58.

13. Hauff, E., & Vaglum, P. (1993). Vietnamese boat refugees: The influence of war and flight traumatization on mental health on arrival in the country of resettlement. *Acta Psychiatrica Scandinavica, 88,* 162-168.

14. Hauff, E., & Vaglum, P. (1994). Chronic posttraumatic stress disorder in Vietnamese refugees. *Journal of Nervous and Mental Disease, 182,* 85-90.

15. Kinzie, J.D., & Boehnlein, J.K. (1993). Psychotherapy of the victims of massive violence: counter-transference and ethical issues. *American Journal of Psychotherapy, 47,* 90-102.

16. Freidman, M., & Jaranson, J. (1994). The applicability of the posttraumatic stress disorder concept to refugees. In A.J. Marsella, T. Bornemann, S. Ekblad and J. Orley (Eds.), *Amidst Peril and Pain: The Mental Health and Well-Being of the World's Refugees.* Washington D.C.: American Psychological Association, pp. 207-227.

17. Westermeyer, J. (1985). Psychiatric diagnosis across cultural boundaries. *American Journal of Psychiatry, 142,* 798-805.

18. Westermeyer, J. (1987). Clinical considerations in cross-cultural diagnosis. *Hospital and Community Psychiatry,* 38, 160-165.

Dr. Boehnlein is Associate Professor of Psychiatry and Director of Medical Student Education in Psychiatry at the Oregon Health Sciences University in Portland. He is a staff psychiatrist in the Indochinese Psychiatry Program and at the Department of Veterans Affairs Outpatient Clinic. He received his M.D. from Case Western Reserve University and M.Sc. in medical anthropology from the University of Pennsylvania, where he was a Robert Wood Johnson Clinical Scholar.

Dr Kinzie is Professor of Psychiatry, Director of Clinical Services, and Director Emeritus of the Indochinese Psychiatric Program at the Oregon Health Sciences University. He received his M.D. from the University of Washington and completed a cross-cultural psychiatry fellowship at the University of Hawaii. His extensive clinical experience includes work in Vietnam and Malaysia.

CLINICAL TRAINING PROGRAM POST TRAUMATIC STRESS DISORDER

The Clinical Laboratory and Education Division for the National Center for Post-Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the Long Beach CA Regional Medical Education Center (RMEC) offers an on-site clinical training program in the treatment of Post Traumatic Stress. The training program is approved for category 1 continuing medical education credit.

Psychiatrists, psychologists, social workers, nurses, readjustment counselors, and clinical nurse specialists combine to provide a comprehensive treatment program and an education experience for the mental health professional seeking to expand his or her understanding of psychological trauma and its treatment. The Clinical Training Program offers a broad range of educational activities including:

* Lectures
* Clinical research observation
* Supervised clinical activities
* Use of multimedia materials
* Group discussions facilitated by staff

Specific training activities include *Warzone Trauma Group Treatment, Treatment of Women Veterans, Combat and Sexual Assault, Relapse-Prevention, Cross-Cultural Treatment Issues, Assessment and Treatment of Families, Use of Art Therapy, Disaster Mental Health, Cognitive aspects of PTSD, Compassion Fatigue, Women working with Men, Assessment of PTSD,* and observation of psychiatric assessment.

Training programs are scheduled for a minimum of one week, although longer programs are available if the applicant can justify an extended stay. Programs are scheduled ten times per year, generally on the third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or RMEC. For further information, please call FTS 700-463-2673 or commercial number 415-493-5000, extension 22673.